VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

October 29, 2013

Ms. Jane White, Administrator
Cota's Hospitality Home
1079 South Barre Road
Barre, VT 05641

Provider #: 0365

Dear Ms. White:

Enclosed is a copy of your acceptable plans of correction for the unannounced on-site re-licensing survey and complaint investigation conducted on **September 16, 2013.** Please post this document in a prominent place in your facility.

We may follow up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

PC:ne

Enclosure

Division of Licensing and Protection

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0365 | A. BUILDING: _____ B. WING _____ | C 09/16/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COTA'S HOSPITALITY HOME | 1079 SOUTH BARRE ROAD BARRE, VT 05641 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| R100 | Initial Comments:<br><br>An unannounced on-site re-licensing survey and complaint investigation were conducted by the Division of Licensing and Protection on 9/16/13. The following regulatory violations were identified. | R100 | | |
| R167 SS=E | V. RESIDENT CARE AND HOME SERVICES<br><br>5.10 Medication Management<br><br>5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions:<br><br>(5) Staff other than a nurse may administer PRN psychoactive medications only when the home has a written plan for the use of the PRN medication which: describes the specific behaviors the medication is intended to correct or address; specifies the circumstances that indicate the use of the medication; educates the staff about what desired effects or undesired side effects the staff must monitor for; and documents the time of, reason for and specific results of the medication use.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview, the home failed to assure that documentation of PRN psychoactive medication administration was completed for 3 of 6 residents sampled (Residents #2, #4, and #6). Findings include:<br><br>1. Per record review on 9/16/13, Resident #2 had a diagnosis of anxiety problems, and was prescribed "Lorazepam 0.5 mg. One tab by mouth every 6 hours as needed for agitation". The nurse had developed a behavior sheet for | R167 | R167, R171, R179, R181<br>POC attached –<br>accepted 10/24/13<br>Karen Campos RN | |

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE



Michael Cota
Jane White LSW / BASW

PNC

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| R167 | Continued From page 1<br>the use of this medication that listed target behaviors and non-pharmacological interventions to try before giving the medication. Per review, he had been administered the Lorazepam three times in July, once in August, and seven occasions in the month of September 2013. There were no notes on the back of the initialed Medication Administration Record (MAR) as to what time it was administered, and what the effect was after taking the anti-anxiety drug. Per review of the behavior sheet for this resident, the staff had failed to fill out any information as to what behaviors were being exhibited, and what interventions may have been tried before resorting to administering the medication.<br><br>2. Per record review on 9/16/13, Resident #4 also had a diagnosis of anxiety along with other mental illness. He was prescribed "Clonazepam 0.5 mg tabs. 1/2 tablet (0.25 mg.) by mouth twice daily", and "Clonazepam 0.5 mg. by mouth at bedtime." There was also a PRN order for "Clonazepam 0.5 mg tabs. Two 1/2 tabs (0.5 mg) by mouth twice daily as needed." There were no indications for use written on the MAR, and staff had not documented the reason for administration in the chart on on the MAR, as well as not filling out the time of or effect of the PRN medication on the resident.<br><br>3. Per record review on 9/16/13, Resident #6 has mental health diagnoses that require the use of an anti-psychotic medication as well as a PRN dose of Lorazepam for agitation. The order for the anti-psychotic read "Quetiapine/Seroquel 25 mg. tablet. 1-2 tabs (25-50 mg.) by mouth every 4 hours as needed." There were no specific indications for use for this PRN medication, and no documentation on the behavior sheets or nursing notes to indicate why the resident needed | R167 | | |

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| R167 | Continued From page 2<br>the PRN dose, and no parameters for distinguishing the need to take either one or two tablets. There was also no documentation to identify whether staff had administered one or two tablets, as the back of the MAR had not been filled out at the time of administration.<br><br>Per interview on 9/16/13 at 1:45 PM, the Registered Nurse confirmed the above-listed dose range of Seroquel, the lack of clear indications for use for Residents #4 and #6, and also confirmed that staff were not completing the behavior sheets to identify the need for the medication based on targeted symptoms,or otherwise documenting the time administered, dose, and effect of the medication on the residents as listed above. | R167 | | |
| R171 SS=E | V. RESIDENT CARE AND HOME SERVICES<br><br>5.10 Medication Management<br><br>5.10.g Homes must establish procedures for documentation sufficient to indicate to the physician, registered nurse, certified manager or representatives of the licensing agency that the medication regimen as ordered is appropriate and effective. At a minimum, this shall include:<br><br>(1) Documentation that medications were administered as ordered;<br>(2) All instances of refusal of medications, including the reason why and the actions taken by the home;<br>(3) All PRN medications administered, including the date, time, reason for giving the medication, and the effect;<br>(4) A current list of who is administering | R171 | | |

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| R171 | Continued From page 3<br>medications to residents, including staff to whom a nurse has delegated administration; and<br>(5) For residents receiving psychoactive medications, a record of monitoring for side effects.<br>(6) All incidents of medication errors.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview, the home failed to assure that required documentation of PRN (as needed) medication administration was complete for 4 of 6 residents sampled (Residents #1, #2, #4, and #6). Findings include:<br><br>1. Per record review on 9/16/13, Resident #2 had a diagnosis of anxiety problems, and was prescribed "Lorazepam 0.5 mg. One tab by mouth every 6 hours as needed for agitation". The nurse had developed a behavior sheet for the use of this medication that listed target behaviors and non-pharmacological interventions to try before giving the medication. Per review, s/he had been administered the Lorazepam three times in July, once on August, and seven occasions in the month of September 2013. There were no notes on the back of the initialed Medication Administration Record (MAR) as to what time it was administered, and what the effect was after taking the antianxiety drug. Per review of the behavior sheet for this resident, the staff had failed to fill out any information as to what behaviors were being exhibited, and what interventions may have been tried before resorting to administering the medication.<br><br>2. Per record review on 9/16/13, Resident #4 also had a diagnosis of anxiety along with other mental illness. He was prescribed "Clonazepam | R171 | | |

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| R171 | Continued From page 4<br>0.5 mg tabs. 1/2 tablet (0.25 mg.) by mouth twice daily." , and "Clonazepam 0.5 mg. by mouth at bedtime." There was also a PRN order for "Clonazepam 0.5 mg tabs. Two 1/2 tabs (0.5 mg) by mouth twice daily as needed." There were no indications for use written on the MAR, and staff had not documented the reason for administration in the chart on on the MAR, as well as not filling out the time of or effect of the PRN medication on the resident.<br><br>3. Per record review on 9/16/13, Resident #6 has mental health issues that require the use of an antipsychotic medication as well as a PRN dose of Lorazepam for agitation. The order for the antipsychotic read "Quetiapine/Seroquel 25 mg. tablet. 1-2 tabs (25-50 mg.) by mouth every 4 hours as needed." There were no specific indications for use for this PRN medication, and no documentation on the behavior sheets or nursing notes to indicate why the resident needed the PRN dose, and no parameters for distinguishing the need to take either one or two tablets. There was also no documentation to identify whether staff had administered one or two tablets, as the back of the MAR had not been filled out at the time of administration. Also for this resident was listed an order for "Diphenoxylate/Atropine (Lomotil) tablet. 1-2 tabs by mouth up to four times daily as needed for diarrhea." This was initialed as given to the resident on 9/1/13, however there was no note on the back of the MAR to indicate the time, how many tabs given, and the effect of the medication.<br><br>4. Per record review on 9/16/13, Resident #1 had issues with chronic pain and was prescribed "APAP w/ Codeine #3 300/30 mg. tab. One tab by mouth four times daily as needed." This had no indication for use written on the MAR, and staff | R171 | | |

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| R171 | Continued From page 5<br>administering the medication had not documented any information on the back to indicate what time the medication was given, or the effect on the resident. In September the medication was given multiple times daily on 14 different days with no documentation.<br><br>Per interview on 9/16/13 at 1:45 PM, the Registered Nurse confirmed the above-listed dose range of Seroquel for Resident #6, the dose range for Lomotil for Resident #6, the lack of clear indications for use for Residents #4 and #6, and also confirmed that staff were not completing the behavior sheets to identify the need for the medication based on targeted symptoms,or otherwise documenting the time administered, dose, and effect of the PRN medication on the residents as listed above. | R171 | | |
| R179 SS=F | V. RESIDENT CARE AND HOME SERVICES<br><br>5.11 Staff Services<br><br>5.11.b The home must ensure that staff demonstrate competency in the skills and techniques they are expected to perform before providing any direct care to residents. There shall be at least twelve (12) hours of training each year for each staff person providing direct care to residents. The training must include, but is not limited to, the following:<br><br>(1) Resident rights;<br>(2) Fire safety and emergency evacuation;<br>(3) Resident emergency response procedures, such as the Heimlich maneuver, accidents, police or ambulance contact and first aid;<br>(4) Policies and procedures regarding mandatory | R179 | | |

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| R179 | Continued From page 6<br>reports of abuse, neglect and exploitation;<br>(5) Respectful and effective interaction with residents;<br>(6) Infection control measures, including but not limited to, handwashing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions; and<br>(7) General supervision and care of residents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interview, the home failed to provide the required 12 hours of annual training for staff with all of the required content for 6 employees reviewed. Findings include:<br><br>Per review of staff training documentation, the hours recorded did not add up to the 12 hours per year for any of the 6 staff members reviewed. On 9/16/13 at 12:15 PM, the Registered Nurse confirmed that the documented training did not meet the 12 hours with all the subject matter required for any of the employees reviewed. | R179 | | |
| R181 SS=F | V. RESIDENT CARE AND HOME SERVICES<br><br>5.11 Staff Services<br><br>5.11.d The licensee shall not have on staff a person who has had a charge of abuse, neglect or exploitation substantiated against him or her, as defined in 33 V.S.A. Chapters 49 and 69, or one who has been convicted of an offense for actions related to bodily injury, theft or misuse of funds or property, or other crimes inimical to the public welfare, in any jurisdiction whether within or outside of the State of Vermont. This provision | R181 | | |

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| R181 | Continued From page 7<br>shall apply to the manager of the home as well, regardless of whether the manager is the licensee or not. The licensee shall take all reasonable steps to comply with this requirement, including, but not limited to, obtaining and checking personal and work references and contacting the Division of Licensing and Protection in accordance with 33 V.S.A. §6911 to see if prospective employees are on the abuse registry or have a record of convictions.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on review of six employee files, the home failed to assure that one staff member worked within the stipulations of a variance issued by the state licensing agency. Findings include:<br><br>Per employee file review on 9/16/13, one employee had a criminal charge identified by a background check. A variance was requested and granted in February 2013 by the Division of Licensing and Protection with the stipulation that they not be allowed to administer medications as part of their job. The employee was trained by the nurse in July 2013 to administer medications, and had been doing so since the training. On 9/16/13 at 2:10 PM, the Registered Nurse and the owner of the home were shown the variance letter in the employee's file, and neither of them were aware of the medication administration restriction stated as a stipulation of employment. on At 3:10 PM, I interviewed the employee who stated that they knew about the variance, but that the home manager had stated that this was taken care of so that they could pass medications. The management at the Division of Licensing and Protection were contacted and not able to find any documentation that the stipulation had been lifted for the staff member to administer | R181 | | |

Division of Licensing and Protection

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| R181 | Continued From page 8<br>medications. | R181 | | |

Cota's Hospitality Home
1079 S. Barre Road
Barre, VT 05641

Survey Corrections.
For September 16 2013 Survey.
October 15, 2013

#1. 5.10 Medication Management:

Nurse and or Manager will check Behavior sheets for all residents taking psychotropic meds and update by Oct 31. Checks and updates will be done monthly when new sheets are put in MAR.
Nurse and or manager will check weekly to confirm completeness of charting on MAR and behavior sheet.

Scheduled inservice on Documentation , Use of Behavior sheets and Plan of correction will be held Wednesday October 23, 2013 from 9:30am to 11:30am. Notice has been posted. Will discuss parameters and to start with lowest dose at inservice as well as complete documentation for medications /behaviors and indication for use of medication.

#2. 5.10 Medication Management 5.10g

List of persons administering medications has been made and will be in medication book by 10/24
Inservice on Documentation to be held 10/23 See above.

5.11 Staff services
5.11b Staff Trainings

Staff trainings for the year have now been set up by L.Kaiser RN
First training 10/23 Staff orientation also set up by RN.
See Attached. Trainings will be held 4th Wed of each month.
Sign in sheets will be used at each training.

RN and manager will coordinate trainings.

5.11 Staff Services
5.11d.

Employee sited has been cleared of charges. New background check has been done and results along with request to change her variance has been sent to Fran Keeler and change in variance has been granted so employee can now administer medications. Delegation training has been done and signed off. Further variances will be copied and given to Director , RN and Manager to review the day they arrive.

Sign off sheets for Employee delegation for the following have been established and put in use as of 10/24
Male catheterization
Glucose monitoring
Medication administration

Director: Michael Cata

Manager: Jane White LPN, BASW

Inservice Training:

BEHAVIOR SHEETS

PLAN OF CORRECTION

DOCUMENTATION

DATE: WEDNESDAY OCTOBER 23

TIME: 9:30 TO 11:30

Part of Training
will include!
and more

PRN MEDICATION DOCUMENTATION:

All prn medications need to have a reason to be given on the MAR

When giving a prn:
MAKE sure there is a current order for the medication:
1. Ask why they need the medication. (Cold sx, fever, pain, nausea, etc) If pain ask them to rate pain 1 to 10.
2. Give medication.
3. CHART: 1.on MAR
2. On back of MAR. Date, time, medication given, dose, and reason medication was taken. Later. Fill in results. Initial.
If medication was for a behavior, (anxiety, voices, etc) make sure to fill out behavior sheet. Remember to try alternative plan to help behavior before giving med.

State suggested that we fill those out daily: if no behaviors put a circle in the box.
Some meds on behavior sheets are routine Will discuss how to chart those on behavior sheet.

In-service training for on-set of employment and annually at Cota's Hospitality Home for all staff.

(This education session will take 4 hours of training.)

- HIPPA- overview
- Resident's Rights, Respectful and effective communication
- Procedure for mandated reporting of abuse, neglect, and exploitation
- Infection Control- including universal precautions, blood bourne pathogens, handwashing
- General safety- environment, emergencies, first aide equipment, skills,
- Staff person must be present on premises at all times to provide general care and supervision
- Medication delegation- assist vs administer, Resident's rights about medication refusal, 5 rights, OTC meds, medication system, Policy for Safe Medication Administration and Assistance, medications that require VS prior to administration assistance

Note: A record will be kept of annual training and complete orientation period of new staff. A minimum of 12 hours per year is required by the state. All in-services will be mandatory.

Staff Name: _____ Year: _____

## Staff In-service log

12 hours of in-service is required per individual staff by state regulations of Vermont. Check the boxes when complete. Must be signed by RN.

☐ Orientation and annual review will include: 4 hours of in-service

1 hour Medication test

- HIPPA overview
- Resident's rights, How to be respectful and effective with communication
- Infection Control – including universal precautions, Blood Bourne pathogens, and hand-washing
- General safety- ambulance procedure, accidents and injuries emergency care, Heimlich, environment, emergencies, first aide equipment, skills, documentation
- Staff responsibilities i.e. must be present on premises at all times to provide supervision and general care
- Procedure for mandated reporting of abuse, neglect, and exploitation
- Medication delegation – assist vs. administer, Resident's rights about refusal of medications, 5 rights, OTC meds, medication system, Policy for Safe Medication Administration and Assistance, medications that require HR or BP prior to administration/assistance

☐ **Delegation of Male In and Out Catheterization**: 2 hour lecture, 1 hour test

- Male anatomy
- Infection Control i.e. clean technique, universal precautions
- Signs and symptoms of UTI
- Reasoning for In and Out catheterization and need for Resident to void prior to procedure
- Importance of recording residuals and rationale
- Supplies needed for procedure and post care

☐ **Documentation/Communication**: 2 hours of in-service and 1 hour test

- What to document and where

- What is important to read i.e. care plan, face sheet, documented notes of last shits that you had off
- PRN medications
- How to document refusal of medications or other care
- Behavior sheets - how to utilize, frequency of documentation
- Documentation required for injury or event
- OTC medications and how they are handled
- Pain assessment – how to monitor and act to the results
- Need for shift to shift report
- Running log documentation
- Documentation for LOA, for >12hrs missing

**Diabetic Education:** 2 hours and 1 hour test

- Diabetes Type one and Type two- differences and why we need to know
- Signs of hypoglycemia and actions to take
- Signs of hyperglycemia and actions to take
- Treatment of hyper and hypoglycemia- actions that need to be taken
- Which medications are used to treat diabetes
- Administering insulin- nurse will make staff aware when "peak time will be"
- Glucose monitoring – different times to take blood sugars in relation to food intake
- Insulin dependent diabetes management for illness that impacts blood sugars or dietary intake
- How to take blood sugar, where to log and why